Healthcare's Metaplasia: we have transplanted far more than organs

David Zigmond

Can we commission, design and manufacture healing cultures and relationships? Or are they better germinated from more natural and vernacular elements? If so, what are these?

This retrospective tale, written in 2015, illustrates what and how much we can lose, and how this happens with our purblind yet insistent reforms.

All human beings have three lives: public, private and secret
– Gabriel Garcia Marques (1928-2014)

In the late 1970s I started working part-time as a medical psychotherapist in a large city hospital, to help psychiatrists and other clinicians. I was chosen because of the variation I offered in interest and experience: an amalgam of general practice, psychiatry and humanistic psychology. Such difference and diversity was then welcomed as a source of professional cross-fertility, not eliminated as a confusing administrative anomaly or contamination as would happen now.

About twenty years later my hospital was then doing pioneering work with bone marrow transplantation. This was powerful but perilous work with few precedents: patients often would have no symptoms yet be told that they harboured a fatal disease. With this shock came an ominous offer: that the only hope of reprieve was to submit to an uncertain procedure which was itself highly dangerous. The treatment offered was long and gruelling – it proceeded by traversing frequently fatal terrains of immunosupression and graft versus host autodestruction. Deaths were common, protracted and distressing; survivals enervating; cures a merciful salvation.

The work of the transplant team was therefore extremely demanding technically, but even more humanly. All patients became immunocompromised and needed protection; they spent many weeks in barrier-nursed isolation. So sequestered, these helpless and hapless individuals brooded – with often wordless fear – on their precarious mortality: dependency needs were intense, yet most often expressed obliquely. Staff had to titrate carefully the precisely objective with the imaginatively intersubjective; scientific detachment with compassionate attachment. For all involved, any possible cure became entangled with physical pain, disfiguration and demands of endurance that became unassimilable. Staff breakdown, withdrawal and masked burnout were common.

Staff feared how this heroically complex work was endangering not just their medical competence, but their own physical, psychological and relational life. Fractious working relationships were an early prodromal sign: worse was to come.

My work with distressed patients led to my work with unravelling staff. I then suggested I work with staff together. This was taken up first with anxious contrition, but then with growing trust and resolve. Medical and nursing staff at all levels would meet weekly for clusters of a few weeks. Attendance was entirely volitional, never required or prescribed. The structure and duration of each cluster was similarly informal and unformulaic: response was to need, never a preconceived agenda. My role was as a facilitator and container – our seeds were respectful disclosure and exploration: the fruit was a more peaceful coexistence with all kinds of distressed uncertainty and anxiety – in themselves, their patients, and with their colleagues.

The meetings developed a distinctive culture of honoured and discrete professional intimacy. This culture was strong and tacitly loyal, yet it had the fragility and elusive paradox of other kinds of intimacy: attempts to subject it to control, management or formal research would have destroyed it. Shame, rage, fear, despair and guilt usually seek disguise at the first glance of public or official scrutiny. I quickly realised that any attempt to quantify the problems and outcomes (by psychometry questionnaires, for example) would deflect the intimate nature of the transactions – an important lesson still to be learned by mental health researchers.

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Within a few years of my starting this substantial but delicate work my hospital became incorporated into the burgeoning reforms to commodify and internally marketise all NHS healthcare provision. This would be done by the commissioning and contracting of all ‘items’ of healthcare between autarkic NHS Trusts. This involved a massive increase in mandatory measurement, defined boundaries of activity and standardised professional packaging.

Due to these reforms, I was no longer employed by the hospital where I had worked for two decades. Instead, I was now accountable to an 'External Provider': a Mental Healthcare Trust.

Notification of this change was soon followed by a managerial visit. We spent about an hour surveying the broad spectrum of my work and its long evolution. They looked frequently puzzled and consternated: many of my activities were unfamiliar to them, and certainly beyond what they had been licensed to commission.

The conundrum crystallised when I urged them to understand my work on the Bone Marrow Transplantation Ward: they were disinclined to do so. It became clear that they knew nothing about this clinical domain, and this ignorance was of little concern to them.

One manager made a small attempt at conciliation: 'Can't we just employ a health psychologist to do this stuff?'

I started to explain why this was unlikely to work: my approach could not be readily designated, packaged or 'contracted out'. It had evolved through gently empirical dialogue, not design; often it followed the hidden and inexplicit – the interstices between the personal and the professional, the publicly proffered and the privately fantasised, the vaunted and the feared. Such territory is often decisive in human affairs yet remains mostly unmapped and strangely unmappable: it lies beyond any designation or speciality. Yet sometimes, opportunistically, we can develop the skills to navigate this misty human hinterland, but only if…

As my analysis of imperilled complexity gathered momentum I sensed the lead manager softly drift away, then stiffen with impatience:

'Look, if the Trusts cannot agree on a clearly defined job description, with contractual specification together with both evidence basis and some kind of tool for measuring outcomes, you're going to have trouble funding anyone to do that kind of work. Whether or not I understand it is immaterial – don't waste your time with that.'

Indeed. If you cannot readily market it, ergo: it can have no value. They would cut, but not know what they were cutting.

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I realised then that we were here all undergoing a kind of bone marrow transplant: one of our working culture. The hospital's outer structure – the cortex – remained unchanged, but its humanity inhabited core – the medulla – was now being replaced with something quite alien. Natural dialogue was being supplanted by management protocols, personal care was being eliminated by procedural treatments.

Our indigenous language and relationships would change utterly.

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My immunity was never suppressed. My graft versus host reaction was consequently long, fierce and painful. It continues to echo.

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Men are more like the time they live in than they are like their fathers
– Ali Ibn-Ali-Talib, *Sentences* (7th century)